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**Executive Summary: Alternative  
Methods of Developing a  
Relative Value Scale of  
Physicians' Services**



**THE URBAN  
INSTITUTE**

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**Project Report**



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This document summarizes the principal findings from The Urban Institute's Project titled "Alternative Methods of Developing a Relative Value Scale of Physicians' Services". Detailed findings are reported in the project's year one report (Urban Institute Project Report 3075-4, February 1983) and its final report (Urban Institute Project Report 3075-8, October 1984).

The year 1 report describes and evaluates five alternative methods of constructing a relative value schedule: charge-based, physician's time, statistical cost functions, micro-costing, and consensus development/social preferences. To the extent possible, each evaluation covers the same basic criteria: data requirements; technical expertise requirements; ability to value certain "problem" types of procedures, e.g., new procedures, or procedures undergoing rapid technical change; potential for future updating; feasibility of developing specialty or location-specific scales; feasibility of implementation at the carrier level; and potential for capturing costs and benefits that occur outside the direct patient-physician encounter.

The final report focuses on the process of actually constructing a relative value scale. It examines the uses and development of existing relative value scales, and some of the consequences and possible distortions that might arise from adopting a fee schedule based on a relative value scale constructed from charge data.

### **Goals and Purposes of Relative Value Scales**

The Health Care Financing Administration is in the process of reevaluating how it pays for medical care. It has adopted prospective payment for hospitals and is considering prospective payment methods for skilled nursing facilities. Payment for physicians' services has been evolving from an essentially open-ended, inherently inflationary system, i.e., the CPR method, to a de facto fee schedule because of Medicare's Economic Index. As more and more physicians' Medicare-computed reasonable charges for specific services exceed the ceilings imposed by the Economic Index, then the ceilings become, in effect, fixed fees paid to all physicians whose reasonable charges exceed the ceiling. In 1984, a de facto fee schedule became a reality, albeit for one year, with the freezing of all fees charged to Medicare.

The evolution of a de facto fee schedule through the Economic Index or perpetuation of a fee freeze will certainly help HCFA attain one of its objectives, limiting its payments for physicians' services. However, this fee schedule is unlikely to reflect very accurately the relative values of different physicians' services. Since value should incorporate both the costs of producing services and patients' (and insurers') preferences, all parties are likely to be unhappy with a de facto fee schedule.

The purpose of this Project is to explore and evaluate alternative methods of constructing relative value scales of physicians' services. A relative value scale is not a fee schedule, though it is an important intermediate step in developing a fee schedule. Given a procedure nomenclature that identifies and defines all the different services a physician can provide, a relative value scale is a cardinal ranking of those services. This



means two things. First, each service's numerical assignment orders that service in relation to all other services. Second, the difference between any two services' numerical assignment measures the difference in some concept of value. In other words, a relative value scale enables one to say something like, "One service is worth ten times another, or is ten times more valuable, or is equivalent to ten units of another."

Although this seems reasonably straightforward, defining "value" is a difficult task. Ideally, a system of relative values should reflect patients' preferences as well as providers' costs. Otherwise, patients may have incentives to use too much or too little of a service, or physicians may have incentives to provide too much or too little.

Values should be consistent with physicians' expenses so that physicians will be willing to provide patients with medically appropriate services. This means that they should be related to the costs of physicians' own time, to the costs of other employees' time, to the costs of equipment and facilities, and to the costs of supplies. For some services, the amount of a physician's time used in producing a service will provide a reasonable approximation of costs; for other services, it will not.

It is difficult to separate physicians' costs from patients' preferences. To begin with, the value, or opportunity cost, of a physician's own time depends in part on how much patients and insurers are willing to pay. In areas in which fees are high, physicians will tend to regard the value of their time as being high as well. Secondly, it may not always be desirable to have services produced in the least expensive way because the costs of some services are sensitive to how many are provided. If, for example, a specialized skill or piece of equipment is used in providing a service, the average cost of the service will be lowest when volume is fairly high. Patients, however, may be willing to pay the higher costs of small scale provision to ensure that a service is available locally. This means that there are likely to be variations in the costs of providing services which will not be attributable to variations in the costs of physicians' time, employees' time, supplies, or facilities and equipment.

There is another reason why ideal relative values should reflect more than just the costs of providing services as cheaply as possible: many of the costs associated with treatment are not borne by physicians. These external costs include such things as hospitalization, time off from work or school, and patients' time. Ideally, fees based on relative values should provide incentives for physicians to offer services which limit these external costs, not just their own expenses associated with providing a service.

Thus, relative values should reflect not only the costs of efficient production but also the preferences and costs faced by patients and society. As a practical matter, this may be an unrealistic objective. A more reasonable goal might be an RVS that avoids giving physicians very wrong signals about relative values.

Once relative values of procedures are determined, the construction of a fee schedule is conceptually straightforward. Assigning relative value units





a monetary value converts the relative value scale into a fee schedule. Each procedure on the scale would have a monetary amount as well as a "pure" number associated with it. If all relative value units receive the same monetary value, then the schedule of relative fees would be identical to the schedule of relative values. Conversely, if some procedures' relative value units are assigned a greater monetary value than others', then relative fees will not be identical to relative values.

The absolute magnitude of the monetary conversion factor obviously determines the absolute level of fees, e.g., a conversion factor of \$10.00 per relative value unit will result in fees ten percent higher than those based on \$9.09 per relative value unit. Since it is relative and absolute fees that ultimately influence physicians' and patients' behavior, determining the appropriate financial conversion factor(s) is a key policy decision.

An extremely important point to note in understanding the relationship between relative value scales and fee schedules is that the monetary factors which convert a relative value scale into a fee schedule are conceptually independent of the relative value scale and can be chosen arbitrarily. In particular, there is no intrinsic reason, other than convenience, for choosing a single conversion factor over multiple conversion factors. Furthermore, if one relative value scale is preferred or chosen over another, then there is no theoretical or inherent reason prohibiting changes in the monetary conversion factor.

### **Summary of the Year 1 Report**

The primary goal of this study's first year was to identify, describe, and evaluate alternative methods of constructing a relative value scale for physicians' services. This is important because, should HCFA decide to switch from CPR reimbursement to a fee schedule to pay for physicians' services provided to Medicare beneficiaries, then developing a relative value scale is an important intermediate step. Five basic methods were evaluated: Charge-based methods, which build relative values from data on physicians' charges; the statistical cost function approach, which would derive relative values from the parameters of a multiproduct cost function for physicians; time-based methods, which use data on the amount of time physicians spend performing various procedures; micro-costing and time/motion study methods, which use information obtained by detailed, on-site observation of the process of producing physicians' services; and consensus development/social preference methods, which rely on expert opinion and/or group decision making to arrive at relative values.

In addition to describing and evaluating the conceptual underpinnings of each class of methods, they were also assessed in terms of several pragmatic implementation criteria. What data are required, are they available, and at what cost? What types of technical expertise are needed to construct and implement relative values? How well does the method assign relative values to certain "problem" procedures, such as new or rapidly changing procedures? How easy would it be to update relative values? Can specialty- or location-specific relative values be constructed? How difficult would it be for individual carriers to construct and/or implement the scale? What is the



method's potential for incorporating into the scale costs and benefits that occur outside the direct patient-physician encounter?

Only two of the methods, the charge-based and consensus development/social preference approaches, appear to be both theoretically sound and feasible to implement at reasonable cost. Although both of these sets of methods have some flaws, they are relatively minor compared to the drawbacks of the other three approaches. Econometric estimation of multiproduct cost functions would require much more detailed data on physicians' practices than are currently available. Furthermore, the statistical properties of cost functions with more than two outputs are unknown. Given the number of outputs that would need to be included for any meaningful relative value scale construction, the odds are that the parameter estimates would be highly unreliable.

Micro-costing and time/motion studies are conceptually straightforward but are extremely expensive to perform. Existing micro-costing studies that include physician as well as other costs involved only a very few institutional settings, usually one. Thus, their results may be very site-sensitive. Furthermore, the extension of similar studies to many sites would be exorbitantly expensive.

Time-based methods depend critically on the assumption that a procedure's value, which includes costs and benefits, is a constant proportion of the amount of physicians' time required to provide the procedures. Except for narrow classes of procedures, however, this assumption does not generally hold. Substantial variations across procedures in nonphysician costs, physicians' investments in training, and the values of outcomes make the relationship between physicians' time input and procedures' values nonproportional and probably nonlinear.

One could adjust observed time to account for these other factors. This would involve a substantial and expensive effort to collect information on variables that are difficult to observe, such as the value of a physician's time and the allocation of fixed costs among procedures. In fact, if such data were collected, then the adjusted time-based method would be essentially equivalent to the more general micro-costing and statistical cost function methods. Finally, there are no large data bases which contain information on physicians' time for procedures identified by CPT-4 or another standard procedure coding terminology.

Relative values constructed from charge data appear to have several desirable properties. Their construction is straightforward. Large, computerized data bases of physicians' charges for procedures identified by their CPT-4 (or similar) codes are readily available at reasonably low cost. (For example, the cost of processing approximately 65,000,000 claims to construct The Urban Institute's California Medicare/Medicaid Claims file was about \$200,000.) Scales are highly invariant with respect to the particular distribution point (mean, median, 75th percentile, or 90th percentile) selected to represent a procedure's absolute charge. Scales constructed from different charge data bases are highly correlated. Scales appear to be stable over time. Finally, for the limited number of procedures for which data are



available, the charge-based scale correlated well with the RV scale constructed by the Mountain Medical Affiliates of Denver, Colorado.

Whether some relative values are too high and others too low cannot be resolved through technical or statistical analysis alone. The review of consensus development/social preference methods showed that group decision-making can be applied to the task of constructing relative value scales. Developing a group decision-making process requires making numerous procedural decisions: group size, group composition, nature of group interactions, voting rules, the definition of value, criteria to be considered, specification of the purpose of the RV scale, range of procedures to be considered, use of experts, etc. How these procedural issues are resolved can obviously influence the outcome. Thus, HCFA's objectives (or those of whoever has responsibility for structuring the process) need to be known before procedural decisions are made.

Probably the most useful application of a consensus development process would be to review, evaluate, and adjust a relative value scale constructed from charges. Given some objective, for example, "Adjust relative values which are 'out of line' with respect to production costs, or HCFA's costs, or different specialists' incomes, or efficacy, or patients' costs (travel time, waiting time, etc.)," a panel would alter the relative values of procedures identified in accordance with the group's instructions. Such a process would obviously be highly political but may be necessary to implement any RV scale, regardless of how it is constructed.

The primary concern over using charges to construct relative values is that charges may be distorted because of uneven insurance coverage among different types of procedures, the inherently inflationary effects of CPR reimbursement systems used by many insurers, and the alleged noncompetitive structure of the market for physicians. Research has shown that insurance does indeed increase physicians' charges, as do CPR reimbursement and non-competitive market structure. It does not follow, though, that if absolute charges are in some sense too high, that relative values constructed from charges will be seriously out of whack compared to what they would be if constructed from "undistorted" charges.

### **Summary of the Final Report**

Obviously, however, policy is not limited to choosing only one method. Accordingly, in the study's second year we focused on the process of actually constructing a relative value scale and converting it to a fee schedule. This report consists of five separate, though related studies pertinent to this general focus.

Chapter I, "Relative Value Scales for Physicians' Services," summarizes earlier findings from the evaluation of charge-based RV scales and compares a prototypical charge-based scale to a time-based scale. It shows that the two scales are clearly different. The time-based approach assigns a much lower relative value to hospital-based procedures, especially surgical procedures, than the charge-based scale. But further analysis reveals that at least some



of the higher charge-based relative values can be explained by higher complexity and urgency compared to office visits.

The second chapter reviews a number of existing relative value scales and their users. An informal survey of contemporary RV scales revealed that most are derivatives of physicians' charges. The most widely used of all RV scales, the California Relative Value Studies, are charge-based. So, too, are many scales used by third-party payers for setting fee schedule values or for filling-in gaps in customary charge screens. The general availability of charge data, and the simplicity of computing relative fees, are reasons for the dominance of the charge-based approach to RV scale development.

Our study also uncovered examples of the less common judgment-based and cost-based relative value scales. An important example of the latter is the hybrid version of the Hsiao-Stason resource-cost-based RV scale employed by the Massachusetts Medicaid program. The fee schedule derived from that scale has been in place for less than a year, and covers only a subset of Medicaid services. Nevertheless, the Massachusetts Medicaid "experiment" should be watched closely. Over time, it should yield important data on the effects of an RVS-based fee schedule vis-a-vis program expenditures, physicians' participation rates, and other aspects of publicly sponsored medical insurance programs.

The past decade was a time of many legal challenges to the development and distribution of physicians' services RV scales. Those challenges were motivated by regulators' concerns that the scales were potential instruments of collusive price setting.

The current legal status of RV scales is still cloudy. Presently, architects and promoters of RV scales do not face the same likelihood of prosecution under antitrust statute as was true in the past. This is due, in large measure, to courts' rejection of the argument that the scales were per se violations of statutes. However, some observers contend that effective legal challenges can still be mounted against RV scales, but it is unclear when and if such challenges will be forthcoming.

Chapter III examines some of the distributional consequences of implementing a fee schedule based on average charges submitted to the Medicare program. (Each procedure's fee is equal to the statewide average of charges for that procedure.) The analysis consists of simulations of Medicare payments to physicians and patients' cost-sharing liabilities for a large number of California physicians. The simulations are compared to actual Medicare payments and cost-sharing liabilities under the CPR system.

The principal result of these comparisons is that a fee schedule need not lead to major redistributions of payments or costs among physicians and beneficiaries. The initial effects of the proposed fee schedule are small. Aggregate program and beneficiaries' payments and practice revenues rarely differed from their present values by more than 3 percent. Belief that payment via fee schedule need not generate fundamentally different outcomes from payment under CPR may help make the former an acceptable policy alternative to all concerned parties.





Even though the fiscal effects of the proposed fee schedule are not large initially, they could be significant in the future. Essentially, the proposed average-charge-based fee schedule represents a schedule of relative payments. Under traditional CPR reimbursement, future payments for Medicare services are a function of growth in physicians' billings over time. That need not be the case for reimbursements under the fee schedule. For instance, the initial schedule of relative fees could be updated via negotiation between the Medicare program and physicians. Under that scenario, annual rates of increase in all or part of the fee schedule need not match corresponding annual increases under an alternative CPR payment scheme. Breaking the explicit link between rates of inflation in physicians' billings and rates of inflation in Medicare allowed payments could go a long way toward reducing the rate of growth in the program's payments to physicians and other providers of medical services.

Chapter IV examines one of the specific criticisms leveled at the use of charge data to construct RV scales--that charges are distorted by variations in insurance coverage. This chapter's goal was to determine the effects of health insurance on prices of physicians' services and, consequently, the usefulness of relative charges as the foundation of a fee schedule. In the empirical analyses of prices of fifty Medicare procedures, insurance elasticities of fee levels were positive and significant in many instances, and consistently fell within a narrow range of values. By implication, a numeraire procedure whose price-responsiveness to health insurance was close to the mean across all procedures would generate a series of relative fees less sensitive than price levels to insurance distortion. Subsequent regression analyses of relative fee equations confirmed that assertion.

In conclusion, the theoretical and empirical results of this study support the contention that relative prices are appropriate as the foundation for the construction of physicians' fee schedules. Before one adapts relative charges to that purpose, additional empirical analyses ought to be performed to confirm this study's findings. This is especially important since the study estimated total health insurance effects from rather gross measures of state-wide insurance coverage undifferentiated with respect to medical procedures.

The report's last chapter focuses explicitly on the process of constructing both a relative value scale and a fee schedule. As suggested above, the recommended approach is a hybrid of the individual strategies analyzed in the project's first year. Three steps are proposed. The first is construction of a relative cost schedule, which would show the relationship among physicians' services on the basis of their resource costs. To the extent possible, this step would focus on the technical process of providing physicians' services in order to develop a reasonably objective basis for the second step, converting the relative cost schedule into a relative value schedule. In this step, insurers would consider how services' benefits to patients, impact on other health care and nonhealth costs, and their own goals and objectives would cause a service's value to deviate from its cost. In other words, relative value is a broader and more subjective concept than relative cost. The third step is choosing one or more monetary conversion factors or multipliers that translate the relative value schedule into a fee schedule. A variety of monetary and policy objectives would presumably dominate this step.



Although there is considerable sentiment for tying fees more closely to costs, focusing only on costs as the basis for fees would divert insurers from the primary goal of a fee schedule--inducing providers to supply the quantity, quality, and degree of access to services they want for their beneficiaries. The ultimate test of how well a fee schedule is performing and whether the fees are right should be in terms of the quantity, quality, and access the fee schedule buys for the amount the insurer spends.

The relationship between fees and costs is really a secondary issue. Insurers may be concerned that they are paying too much for some services because physicians are extracting monopoly profits on services for which patients' demand is insensitive to price. Insurers could test their suspicions simply by paying less for those services, and they should continue to pay less until either quantity, quality, or access decline to unacceptable levels.

A key feature of the process we describe is that it relies heavily on judgments at every step, albeit supplemented by data and technical calculations. To the extent that the "right" fee schedule requires making tradeoffs between spending and quantity, quality, and access as well as among the latter three dimensions of physicians' services, then having to make judgments will be inevitable. Developing a formula that links fees to resource costs or some combination of measures of costs and other factors will remove the need to exercise judgments, but will probably also lead to a poorly performing fee schedule.

Political considerations would seem to require insurers, especially Medicare and Medicaid, to use cost information in order to justify changes in relative and/or absolute fees. Primarily for this reason, the process we have outlined begins with the development of a relative cost scale for physicians' services. Even so, we do not believe that major expenditures should be made to conduct large scale cost-finding studies, which would be very difficult to perform reliably. Rather, insurers' primary efforts should be directed toward developing data systems and methods for measuring quantity, quality and access and deciding whether the services physicians provide under the fee schedule are right or appropriate for their beneficiaries. Obviously, these tasks will not be easy, but pursuing them is more likely to contribute to a better system for paying for physicians' services than trying to identify the "true" cost of providing services.

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\*In the extreme example of monopoly profits, patients' demand for the service would be characterized by a vertical line intersecting an upward sloping supply function. Implicit in the supply function are the costs of acceptable quality and access for that particular quantity of services. If the price being paid is above the price consistent with the intersection of the demand and supply functions, then lowering the price means moving down the vertical demand function. A lower price would thus affect only physicians' profits, and would have no impact on quantity, quality, or access until it fell below the price implied by the intersection of the two functions.



As a practical matter, it may not be desirable to implement a fee schedule that departs too radically from existing average charges. For one thing, major changes are likely to create substantial political opposition from physicians who would be financial losers and from patient groups who might fear disruptions in access and reductions in quality of care. For another, there is very little actual experience in constructing a relative value scale from other than charge data, converting that scale into a fee schedule for achieving specified objectives in addition to paying for services, and knowing precisely how physicians will respond.

In order to increase political acceptability and to minimize the costs of making mistakes in calculating fees, insurers may wish to constrain changes to be no more than 5 or 10 percent greater or smaller than existing average charges, for example. If experience over the first year of the fee schedule did not highlight major problems or unexpected effects, then fees could be adjusted by another 5 to 10 percent on a periodic basis until the transition to the desired fee schedule was completed.

There are several questions which this study has not addressed at all or barely touched on.\* How should physicians' services be defined--by a detailed procedure coding terminology, a single, all-inclusive package of care per person, or something in between? How should physicians be compensated--by fee-for-service, salary, or capitation? How can market forces be incorporated into the regulatory process of setting fees? Under what circumstances should physicians be allowed to bill patients amounts in excess of the fee schedule? What is the role of cost sharing? Should so-called "cognitive" services receive special recognition? Each of these could by itself be the topic of a lengthy report. We briefly discuss three of them: fees for cognitive services, the role of the market, and the universality of a fee schedule.

The process we've outlined for constructing a fee schedule cannot resolve the cognitive vs. procedural services debate.\*\* But we believe that it suggests an alternative way of addressing the issue. From a social policy perspective, the main concern should be whether the possible disparity in reimbursement for cognitive and procedural services results in a mix of services which does not maximize patient welfare, i.e., too many procedures and not enough consultation and counseling. Unfortunately, the debate has centered primarily on the difference between fees and costs. The main argument seems to be that cognitive services are undervalued relative to

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\*For discussions of some of these issues, see J. Hadley, "How Should Medicare Pay Physicians," Milbank Memorial Fund Quarterly/Health and Society (Spring 1984); J. Mitchell et al., Alternative Methods for Describing Services Performed and Billed, Health Economics Research, Inc. (Boston: 1984); and J. Holahan, "Physician Reimbursement," in J. Feder et al., National Health Insurance, Urban Institute Press (Washington: 1980).

\*\*See for example, American Society of Internal Medicine, "Reimbursement for Physicians' Cognitive and Procedural Services: A White Paper," Washington, D.C., January 1981; "Cognitive Services Payment Increase Urged by Internists," American Medical News, October 16, 1981.



procedural services because the implicit rate of return per unit of physician effort appears to be so much lower for cognitive services than for procedural services. The principal counterargument has been that these calculations do not properly take into account differences in skill, complexity, training, risk, etc., required to perform a procedural service relative to a cognitive service. From a more venal perspective, some physicians who provide cognitive services argue that this disparity is unfair because their practices don't give them the opportunity to provide financially lucrative procedural services.

Taking the last point first, many other professions and occupations, such as ballet dancers, teachers, and gas station attendants, also have little or no opportunity to perform procedural services. But this fact would hardly justify paying more for ballet tickets, school budgets, or gasoline. Nor would paying more for these other services, in order to eliminate the apparent inequity in providers' payment per hour, make procedural services any less lucrative financially.

It may very well be that relative fees for cognitive and procedural services are out of line. But this judgment should be based on assessments of whether people are getting too many or too few of one or the other kinds of services. Again, making these assessments is not easy. They would require gauging whether people have trouble obtaining cognitive services, whether more cognitive services would improve outcomes (medically and/or fiscally), and whether too many procedural services of marginal or no benefit are being performed. Answers to these questions would signal how relative fees ought to be adjusted.

It should be remembered that even under the current Medicare payment system of customary, prevailing, reasonable reimbursement in which relative fees are supposedly out of line, the payments for the various categories of "visits" comprise by far the largest part of spending for physicians' services. In California in 1978, 17 visit codes accounted for 71.5 percent of all Medicare services provided by a large sample of physicians.\* For the most part, the visit categories in the CPT coding scheme reflect the various cognitive activities that physicians carry out. (Certain cognitive activities, such as telephone contacts, reading, etc., do not have codes for reimbursement purposes.) It would seem that at least some of the concern that patients do not receive an appropriate mix of services may go to the content of these visits and not to an underprovision of visits. If this is so, then the issue is not fees-for-visits compared to fees-for-procedures, but the absence of procedure codes that describe true cognitive activities.

Some may contend that physicians who provide procedural services are able to extract monopoly profits. If true, then fees for those services could and should be lowered. Also if true, the quantity and quality of procedural services provided should not fall until the fee drops below costs. But knowing the cost of procedural services in advance is not essential to decide

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\*Unpublished data, The Urban Institute.





to lower fees. Furthermore, the cost of cognitive services is absolutely irrelevant to the question of whether the fees for procedural services include monopoly profits.

Our approach may frustrate those who seek to determine where truth lies, just as economic realities frustrated theologians who sought the just price. Even with the right data, whoever is paying must decide what they want in order to set fees correctly. No objective truth exists for an issue like this. We encourage insurers to evaluate what they get for their payments rather than the relationship between payments and resource costs. Only this way can insurers ask the right questions and collect the right data for making good judgments.

To the extent that the modern fee schedule is no more than the ancient just price, will market forces make fee schedules anachronistic? Can regulatory fee schedules incorporate or take advantage of market-generated pressures? In the discussion of setting monetary multipliers, which convert the relative value schedule into a fee schedule, we described one possible way of meshing the market with fee schedules: setting up a system whereby physicians submit their own multipliers as "bids" to be accepted or rejected by Medicare.

Another approach, which is more in keeping with existing Medicare practice, is to permit physicians to bill patients for charges in excess of the fee schedule amount. Unlike the current system, Medicare could also permit rebates for charges below the fee schedule amount. In this way, patients would not be denied access to quality care where overall demand is high or physicians are in short supply. Nor would they have to pay more than the going rate where demand is "soft" and physicians are engaging in widespread fee discounting. Perhaps just as important, data on physicians' charges relative to fee schedule amounts would aid insurers in adjusting their fee schedules to keep pace with changing market conditions.

Strengthening patients' incentives to shop for physicians and be prudent purchasers would obviously enhance market forces. Several options are possible. One is to vary cost sharing obligations with the costliness of the provider. Another is to permit rebates to patients who obtain care from providers charging less than the fee schedule amount. For example, the patient might receive half of the difference directly from the insurer, with the insurer keeping the other half as program savings which could be applied toward future program expenses in order to lessen premium growth. In other words, rewarding patients for prudent purchasing will reinforce possible penalties for imprudent purchases.

A possible advantage of maintaining a dual system of fee schedule amounts and physicians' charges (above or below the fee schedule) is that average charges can serve as a continuous monitor of how close the fee schedule amount is to market conditions.\* Unlike the system of physicians' submitting individual bids for an annual multiplier, charge data could be collected on an

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\*See Hadley (1984) for further discussion of this point.



ongoing basis for all services. Not only are they more continuous than annual or periodic bidding, they also provide a mechanism for making adjustments to relative values and relative fees. Not all changes in market conditions will affect all services uniformly. Changes in a single or a few multipliers may not be able to detect such variations very precisely. Comparing relative and absolute charges to relative and absolute fee schedule amounts may provide better information about how to make changes.

Permitting physicians to bill patients amounts different from the fee schedule may be desirable for other reasons as well. In spite of the large number of procedures and the precision with which a procedure coding terminology defines them, there will inevitably be variation in the quality, convenience, and amenities people wish to purchase and providers are willing to provide. A uniform fee schedule which applies to all physicians and to all patients will discourage these variations. To the extent that high quality (as opposed to average quality) care is more expensive to provide, physicians will be reluctant to offer it. To the extent that patients want high quality care, they will have difficulty finding it. These types of conflicts are likely to arise where specialists and generalists provide the "same" service, and where more and less complicated cases of the "same" illness receive the "same" services.

The choice between equity and uniformity, on the one hand, and freedom of choice and diversity, on the other, is essentially political. Generally, the American way seems to favor the latter. If this in fact is the choice made, then separate means of insuring low income people adequate access to care of acceptable quality should also be an objective of the health care financing, payment, and delivery systems.





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